DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

AOC #2 accepted

PRINTED: 08/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445047	A. BUILDING _____ B. WING _____	C 08/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL GARDENS HEALTH AND REHABILITATION	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint investigation #28552 and #28495 were completed at Imperial Gardens Health and Rehabilitation Center August 15, 2011, through August 20, 2011, with a partial extended survey completed on August 20, 2011. Complaint #28552 was substantiated with F-333 cited at a scope and severity level of "J" (Substandard Quality of Care). The facility failed to ensure one resident (#11) was free of significant medication errors which placed resident #11 in Immediate Jeopardy. Complaint #28495 was substantiated and F-323 cited at a scope and severity level of "G" (actual harm) related to an inappropriate transfer resulting in a fracture for resident #1. The Administrator and Interim Director of Nursing were notified of the Immediate Jeopardy on August 19, 2011, at 3:30 p.m., in the conference room. The Immediate Jeopardy at F-333 (Substandard Quality of Care) was cited at a scope and severity of "J" effective August 6, 2011, and is ongoing.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rene' Sharp — TITLE: Interim Administrator — (X6) DATE: 8/31/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the family of a significant medication error for one resident (#11) of thirty-one residents reviewed. The findings included: Resident #11 was admitted to the facility on July 11, 2011, with diagnoses including Diabetes, Cerebral Artery Occlusion, Cerebral Infarction, Chronic Anticoagulation, Hyperlipidemia, and Diabetic Retinopathy.	F 157		

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F 157	Continued From page 2 Review of a Physician's Order dated August 5, 2011, revealed,"(Coumadin) Warfarin Sodium 4 mg (milligrams) Tablet (medication that thins the blood) by mouth at bedtime 9:00 p.m. Sat, Sun, Tues, and Thurs (Saturday, Sunday, Tuesday and Thursday)...(Coumadin) Warfarin Sodium 3mg Tablet by mouth Mon, Wed, Fri (Monday, Wednesday, and Friday) at 9:00 p.m..." Medical record review of the facility's investigation dated August 11, 2011, revealed, "...Order = (equals) Coumadin 3 mg po (by mouth) M, W, F (Monday, Wednesday, and Friday). Coumadin 4 mg Sun, Tues, Thurs, Sat (Sunday, Tuesday, Thursday, and Saturday). On 8/6/11, 8/7/11, and 8/8/11, received Coumadin 7 mg...The LPNs (Licensed Practical Nurses) did not read the orders, they just looked at the empty spaces on the MAR (Medication Administration Record), gave the med. (medication) and went on..." Medical record review revealed no documentation the family was notified of the significant medication errors (resident received seven milligrams of coumadin for three consecutive days). Interview with the Interim DON (Director of Nursing) on August 17, 2011, at 2:10 p.m., in the conference room, confirmed the facility failed to notify the family of the resident receiving 7 mg of Coumadin for three days instead of Coumadin 3 mg alternating with Coumadin 4 mg.	F 157		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 3	F 281		

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, the facility failed to follow Physician's Orders for the administration of a medication for one (#31) of thirty-one residents reviewed.

The findings included:

Resident #31 was admitted to the facility on May 11, 2011, and re-admitted on June 30, 2011, with diagnoses including Hypertension, Dementia, and Myocardial Infarction.

Medical record review of a Physician's Re-admission Orders dated June 30, 2011, revealed, "Senna 15 mg (milligrams) Tablet by mouth bid (twice a day), 0800 (8:00 a.m.), 2000 (8:00 p.m.) for constipation."

Medical record review of the Physician's Recapitulation Orders for July and August, 2011, revealed, "Senna 15 mg Tablet by mouth bid. 8:00 a.m., 8:00 p.m. (Hold for diarrhea): For Constipation."

Medical record review of the Medication Administration Record dated July,2 2011, through August 18, 2011,revealed, "Senna 15 mg Tablet by mouth bid. 8:00 a.m., 8:00 p.m..."

Observation of the medication cart on August 18, 2011, at 10:45 a.m.,with the medication nurse (#7) on the west wing, revealed Senna 8.6 mg tablets in the cart.

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F 281	Continued From page 4 Interview with the medication nurse (#7) on the west wing on August 18, 2011, at 10:45 a.m., in the hall, revealed, "I have always given two tablets of Senna 8.6 mg (to resident #31)." Interview with the Restorative Nurse Assistant on August 18, 2011, at 11:00 a.m., on the west wing, confirmed, "The resident received Senna 8.6 mg bid, but on June 30, 2011, the admission nurse entered Senna 15 mg bid into the computer (ECS-Electronic Computer System)." Interview with the MDS (Minimum Data Set) Nurse #1 on August 20, 2011, at 9:10 a.m., in the conference room, confirmed, "I called the Physician to validate the order for Senna 8.6 mg bid on June 30, 2011, but I failed to write the order or put it in the computer.	F 281		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility provided documentation (investigation),	F 323		

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F 323	Continued From page 5 observation, facility policy review, and interview, the facility failed to provide the assistance of a two-person transfer or the use of a mechanical lift during a transfer for one resident (#1) of thirty-one residents reviewed. The facility's failure to provide adequate assistance for resident #1 resulted in a fractured tibia and fibula (Actual Harm). The finds included: Resident #1 was admitted to the facility on October 9, 2009, with diagnoses including Senile Dementia, Hypertension, Osteopenia, Cardiovascular Accident, and Dysphagia. Medical record review of the MDS (Minimum Data Set) dated July 12, 2011, revealed the resident required total assistance with transfers and all activities of daily living. Review of the current care plan dated May 14, 2011, revealed, "... Use gait belt when assisting with transfers..." Review of the facility's CNT (Certified Nurse Technician) Care Card (card that instructs the CNTs on the care of the resident) dated July 30, 2011, revealed, "...Requires 2 people for transfers and for bed mobility and may use lift..." Further review revealed the CNT Care Card did not match the current plan dated May 14, 2011. Review of the facility's investigation dated July 31, 2011, revealed, "Current intervention: transfer assist x (times) 2/mechanical lift (transfer with the assistance of two or use of a mechanical lift)..."	F 323		

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F 323	Continued From page 6 Medical record review of a nursing note dated July 31, 2011, at 9:19 a.m., revealed, "INCIDENT TYPE: other: left foot/leg caught in side rail during transfer. DATE OF INCIDENT: 07/30/2011. TIME OF INCIDENT: 10:30 p.m...night shift. Description of Incident: After being transferred to bed, left leg became wedged between side rail, which was down, and bed. CNT described hearing a "POP" and then the resident's leg was between the rail and the bed. This resulted in a 3.5 inch x 1.5 inch raised area to left shin. No bruising. Swelling present...pain and swelling to left lower anterior leg...FIRST AID: emergency room: POSSIBLE CAUSE:...STAFF INVOLVED..." Medical record review of a Physician's Order dated July 30, 2011, at 11:15 p.m., revealed, "transfer to...(local hospital)..." Medical record review of a Radiology Report dated July 31, 2011, revealed, "...On the left there is an oblique fracture of the distal third of the tibia with fracture fragments in near anatomic alignment...there is also a fracture of the distal fibular diaphysis...There is severe extensive Osteopenia...The fibular fracture may be old, although this is not certain." Medical record review of a Hospital Physician's History and Physical dated July 31, 2011, revealed, "...The patient has mild tenderness to palpation about the left mid shaft tibia. (Resident's) compartments are very soft and compressible...(resident) has no pain..." Medical record review of the hospital discharge instructions dated July 31, 2011, revealed, "...This	F 323		

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F 323	Continued From page 7 type of injury often occurs when the ankle is severely twisted causing tearing of the ankle ligaments and also a break in the bone that the ligaments are holding together..." Medical record review of a nursing note dated August 1, 2011, at 10:29 a.m., revealed, "Returned from...(local hospital) ER (Emergency Room). Splint to left leg. Ace wrap from foot to mid thigh..." Review of the facility's investigation dated August 1, 2011, revealed, "Resident was being transferred from the shower chair to the bed when the left leg became entangled in the side rails. The side rails were in the low position. The CNT reported hearing a sound when she lowered (resident) onto the bed. The RN (Registered Nurse) was immediately notified and the resident was transferred to...(local hospital) where it was determined that...(resident) had fractures of the distal one-third of the tibia and fibula...(resident) was returned to the facility the following morning..." Review of the facility's documentation dated July 31, 2011, of an interview conducted by a RN (Registered Nurse) with the CNT that transferred the resident on July 30, 2011, revealed,"...(RN) asked (CNT) if CNT was aware of how many staff were supposed to transfer the (resident)...Ask why (CNT) attempted the transfer alone and (CNT) stated, "(Resident) was in a good mood and had been cooperative and everyone else was busy and (CNT) thought (CNT) could do it alone..." Review of the facility's investigation dated July 31,	F 323		

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F 323	Continued From page 8	F 323		

2011, revealed, "(The CNT who transferred the resident) reported to be aware of the transfer status of the resident but made the decision to transfer the resident independently....(CNT) also reported did not use the gait belt which is also facility policy for use during transfers."

Observation on August 15, 2011, at 8:30 a.m., revealed the resident lying in bed, asleep. Continued observation revealed a cast to the left lower leg.

Review of the facility's policy for Transfers revealed, "It is the policy of this facility that a gait belt must be used when any resident is being ambulated. The gait belt must be applied before the resident stands."

Interview with the Registered Nurse (#4) (who was working on the East Hall on July 31, 2011) on August 15, 2011, at 5:00 p.m., by phone, revealed, "The CNT called me to the room on July 30, 2011, about 10:00 p.m., and stated when (CNT) stood and pivoted the resident, (CNT) heard a popping sound. I examined the resident and sent (resident) to the Emergency Room. I asked the CNT why (CNT) attempted to transfer the resident, knowing it required two people. The CNT stated, "I didn't have any one to help me." I told CNT that (CNT) had not called for any help."

Interview with the Administrator on August 15, 2011, at 1:00 p.m., in the conference room, confirmed the CNT failed to transfer the resident with the assistance of two people or the use of a mechanical lift, resulting in a fracture of the tibia and fibula (Actual Harm).

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F 323	Continued From page 9 C/O 28495	F 323	**Allegation of Compliance for Removal of Immediate Jeopardy** **F333J Residents Free of Significant Med Errors**	
F 333 SS=J	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of a facility investigation, review of facility policies and procedures, and interview, the facility failed to prevent three consecutive significant medication errors when administering Coumadin (an anticoagulant that thins the blood to prevent clot formation) for one (#11) of fourteen residents receiving anticoagulation medication. The facility's failure to administer the correct dosage of Coumadin as ordered by the physician caused resident #11 to experience a critical PT/INR (Protime/International Normalization Ratio-lab test used to determine therapeutic levels for blood thinning medications) resulting in hospitalization and placing the resident in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment or death). A meeting was held on August 19, 2011, at 3:30 p.m., in the conference room, with the	F 333	**1. Immediate Corrective Action.** **Resident # 11** was transferred to the acute care hospital on 8-9-2011 by the registered nurse(RN) on duty upon the awareness of an elevated PT/INR level of 9.2. The Nurse Practitioner was notified. The RN on duty then reviewed Resident # 11's Medication Administration Record (MAR) and found that the resident had received three incorrect doses of Coumadin over the previous three days. The RN on duty immediately notified the on-call Nurse Practitioner, the attending physician and the Interim IDON (IDON) and was instructed by the IDON on to immediately initiate the investigation of the error that night. The IDON continued the investigation on 8-10-2011 by reviewing all residents on Coumadin therapy and the process of alternating patterns when writing Physician's orders. Alternating patterns means medications ordered to be administered on different days and/or medication doses to be given at different times. (i.e. Coumadin 3mg Monday, Wednesday, Friday and/or 4 mg Saturday, Sunday, Tuesday, Thursday). The findings of the facility investigation were reported to the Administrator and the Quality Improvement Coordinator (QIC) on August 10, 2011. The nurse who transcribed the physician order failed to use the appropriate order structure. Therefore, the alternating	

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F 333	Continued From page 10 Administrator and Interim Director of Nursing, to inform the facility of the Immediate Jeopardy. The Immediate Jeopardy was effective August 6, 2011, and is ongoing and Substandard Quality of Care. The findings included: Resident #11 was admitted to the facility on July 11, 2011, with diagnoses including Cerebral Arterial Occlusion with Cerebral Infarction, Peripheral Vascular Disease, Peripheral Arterial Disease, and Diabetes Mellitus Type II. Medical record review of a PT/INR dated July 9, 2011, (while in the hospital prior to admission to the facility) revealed, "...PT 20.1; INR 1.93 (Normal Range: PT 9.6-12.5; INR 2.0-3.5)..." Medical record review of the Admission Physician Order dated July 11, 2011, revealed "... [Coumadin] Warfarin Sodium 4 MG (milligram) Tablet by mouth at bedtime..." Medical record review of a PT/INR dated July 12, 2011, revealed "...PT 23.8; INR 2.4 (Normal Range: PT 9.0-11.0; INR 0.90-3.5)..." Medical record review of a Physician's Telephone Order dated July 12, 2011, at 12:00 p.m., revealed "...Continue Coumadin 4 mg po (by mouth)..." and at 1:00 p.m., " ...PT/INR in one month ..." Medical record review of the Physician Recapitulation Orders dated July 2011, revealed "...LAB: PT (Protime-INR) lab date: 08/09/2011..."	F 333	doses of the medication were not correctly sent to the MAR. The Registered Nurse who transcribed the physician order on 8-6-2011 received a written performance correction notice by the IDON on 8-11-2011 for failing to ensure the physician order was clearly transcribed into the Electronic Charting System (ECS). The IDON gave immediate education/training on 8-11-2011 regarding the proper procedure for entering physician orders into the Electronic Charting System (ECS) and then referring back to the MAR to review and assure that it entered correctly. The two LPN's involved in the incident both received a written counseling on 8-11-2011 by the Registered Nurse for making a medication error involving Coumadin. The Registered Nurse gave immediate education/training on 8-11-2011 to the two LPN's involved regarding the five rights of administering medication thoroughly reading the physician orders and clarifying the order if there are questions prior to giving medications. The resident is no longer at this facility. **2. Identify Other Residents at Risk and corrective action taken.** Residents receiving medications have the potential to be affected by this practice, including, but not limited to, residents who have daily coumadin orders. Beginning on August 10, 2011 the physicians' orders in the residents' medical records were reviewed facility wide by the IDON and Licensed Practical Nurse (LPN) to assure that no other transcription errors related to Coumadin therapy had occurred. This "match back" process was conducted by a Licensed Practical Nurse (LPN) and the	

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F 333	Continued From page 11 Medical record review of a Nurse's Note dated August 5, 2011, at 4:43 p.m., revealed the resident was taken to an outside doctor's appointment and new Coumadin orders would be sent to the facility. Continued medical record review of a PT/INR results dated August 5, 2011, obtained during the visit to the doctor's office, revealed a PT of 39.7 and INR of 3.3 (Normal Range: PT 11.5-13.5; INR 1.0-3.0). Medical record review of a Physician's Telephone Order dated August 6, 2011, revealed "...Coumadin M, W, F, (Monday, Wednesday, Friday) 3 mg...Sun, Tue, Thur, Sat (Sunday, Tuesday, Thursday, Saturday) 4 mg (The order was received via fax on August 5, 2011, as a result of an appointment with a private physician on August 5, 2011; the order was entered into the computer (ECS-Electronic Charting System) on August 5, 2011. Medical record review of the August 2011, Medication Administration Records (MARs) revealed the resident was to receive alternating doses of Coumadin 3 mg (M, W, F); and 4 mg of Coumadin (Sun, Tue, Thur, Sat). Further review revealed the nurse administered the following incorrect doses of Coumadin: August 6: 7 mg given-correct dose was 4 mg August 7: 7 mg given-correct dose was 4 mg August 8: 7 mg given-correct dose was 3 mg Medical record review of a PT/INR dated August 9, 2011, revealed "...PT 91.9...INR 9.3 (Normal Range: PT 9.0-11.0; INR 0.90-3.5)...VALUE EXCEEDS CRITICAL LEVEL..." Continued review of the physician's order confirmed the physician was notified and gave orders to hold	F 333	IDON. This process checked the physician orders in the electronic charting system (ECS) and matched them to the Medication Administration Record (MAR) focusing on transcription errors. No other discrepancies were found. Beginning August 17, 2011 as part of ongoing quality improvement this process was repeated facility wide by MDS RN, MDS LPN, Staff RNs, Staff LPNs, LPN Unit Clerk, LPN Admission Nurse, LPN Medication Managers and Contract LPN lead by the IDON. This team audited physician orders, MARs and medications for all residents. The process checked the written physician orders on the medical record against the physician orders in the electronic charting system (ECS). Then, the physician orders were matched to the MAR and checked against the medications available in the medication carts. The only discrepancy noted was for one resident and one medication that had a start/stop date with the start date starting one day late. The physician was notified by the LPN conducting the audit and the physician extended the period of time for the medication for one day. This audit process was completed on August 19, 2011. The 24 hour report automatically pulls all new physician medication orders for the previous day to the 24 hour report. This 24 hour report is utilized to identify all new physician medication orders written. All	

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F 333	Continued From page 12 the Coumadin for three days and repeat the PT/INR to determine accuracy. Medical record review of a Physician's Telephone Order dated August 9, 2011, at 10:00 p.m., revealed "...Send to (name) hospital for evaluation & (and) treatment elevated PT 90.7...INR 9.2... " Medical record review of a (Late Entry) Nurses Note dated August 10, 2011, revealed "...Transfer/DC (Transfer/Discharge): 08/09/2011...11:15 p.m., via ambulance...to (name) hospital for evaluation and treatment..." Medical record review of a hospital Emergency Room Report dated August 10, 2011, revealed the resident was seen at 12:08 a.m.. Continued review revealed "...Chief Complaint: abnormal labs...Labs (repeated in the emergency department)...PT 97.0...INR 9.90...Course of Care: Vit K 5 mg po given (Vitamin K- used to reverse the anticoagulation effect of Coumadin)...Disposition: Admitted....Clinical Impression: Coagulopathy (a disorder in which the blood is too slow to clot)..." Review of a facility investigation for a medication error initiated on August 9, 2011, revealed "...transcription error (occurred) 8/5/11...Today's date: 8/9/11...Date of Incident 8/6, 8/7, 8/8 med (medication) administration...Medication Involved: Coumadin...Time Incident was Discovered: 8:45 p.m....How Incident was Discovered: Resident with elevated INR-investigated MAR (Medication Administration Record) & Coumadin dosage...To ER (Emergency Room)...Order=Coumadin 4 mg Sun, Tues, Thurs, Sat, Coumadin 3 mg M, W, F,	F 333	new physicians' medication orders entered by the licensed nurse are reviewed daily for appropriate format in the ECS by the IDON, or designee. This review is completed within 24 hours of any newly transcribed medication order. This includes the name of the drug, the dosage, the route, the frequency, the time and the reason (diagnosis) for the medication. Any errors or inconsistencies in the format of the medication order are immediately corrected by the IDON or designee. On January 7, 2011 the process for a Medication Pass Exception Report was initiated. This Medication Pass Exception Report identifies any resident whose medications were omitted and the reason for such. The Medication Pass Exception Report is automatically generated from the ECS and is printed after each medication pass by the RN/LPN Medication Nurse. This report is reviewed with the RN Team Leader and RN/LPN Medication Nurse at the end of each shift. Additionally, it is reviewed daily (within 24 hours of completion) by the IDON or designee. The reason for any medication omitted is written on this report and in the nurses' notes. If an error is detected, the Team Leader Nurse immediately, at the time of discovery, notifies the IDON and the attending physician either in person or by a telephone call. The error is corrected/resolved by the Team Leader Nurse and the responsible party/Power of Attorney is notified of the incident. A medication error report is completed with the nurse who made the error for the purpose of ongoing quality improvement, and personal education and	

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F 333	Continued From page 13 on 8/6/11, 8/7/11, & 8/8/11 received Coumadin 7 mg (Coumadin 4 mg on Sunday, Tuesday, Thursday, Saturday and Coumadin 3 mg on Monday, Wednesday, Friday)...How did it Happen:...The LPN's (Licensed Practical Nurses) did not read the orders they just looked at the empty spaces on the MAR, gave the meds & went on...Classification of Medication Incident...1. Dosage Form...Cause of Medication Incident...8. Transcription Error...Follow Up: Reviewed with employee Registered Nurse (RN) Team Leader correct inputting into ECS & then to pull-up the MAR to ensure that it prints out correctly to the MAR. Will spot review ordered enter (entered order) into computer during shift-will use 24-hour report to use as potential orders to be reviewed...RN Team Leader to in-service med nurses... " Continued review of the facility investigation initiated on August 9, 2011, of an in-service dated August 11, 2011, at 10 p.m., revealed "...Teachable Moments Topic: Reading Coumadin order thoroughly before giving medication...Point(s) of Interest: 1. Two Coumadin orders does not always mean they are to be given on the same day & time. 2. You must read the orders on the MAR prior to giving medication. 3. Remember the 5 rights of giving medication. 4. If the order does not sound right question it by referring back to the resident's chart. 5. Be more aware of your resident's medication & doses..." Review of the facility's "Notation and Processing of Physicians' Orders" policy and procedure dated 2004 and Revised 2010, revealed "...Policy...It is the policy of this facility that all Physicians' orders	F 333	training. Then, the Exception Report is signed by the medication nurse and the Team Leader Nurse and given to the IDON. This process is part of our entire medication check process to assure residents are receiving medications appropriately. This process is ongoing. Beginning August 23, 2011 the MAR in the ECS is reviewed and compared to the current physicians' medication orders seven days a week by the RN/LPN to monitor and prevent a medication error. The results of this monitoring are reported to the IDON daily. This review/monitoring process is ongoing. When a resident is admitted or readmitted to the facility, the transfer plan of care recommendations from the hospital are reviewed with the attending physician by the Corporate RN Admission Coordinator or designee and either confirmed or revised by the attending physician. The confirmation or revision of recommendations takes place upon receipt of the orders from the transferring facility and confirmation that the resident is indeed being admitted. The confirmed admission orders are then entered into the Physicians' Orders in the ECS by the Corporate RN Admission Coordinator or designee. These orders are double checked by a RN/LPN upon admission of the resident into the facility to assure that no inconsistencies are present and that the order entry process was completed accurately and timely. This double check process continues by a RN/LPN per facility process, monitoring the MAR against the physicians'	

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F 333	Continued From page 14 will be appropriately transcribed and noted by a licensed nurse...Procedure...b. The nurse who notes the order will transcribe the order onto the appropriate Medication Administration Record (MAR), Treatment Administration Record (TAR), and/or other records...e. A licensed nurse between the hours of 12:00 midnight and 6:00 AM will review all physicians' verbal and/or telephone orders on a daily basis. The nurse will indicate his/her review and verification of accurate implementation by the nurse who noted the order, by documenting in red ink beneath the previous nurse's signature: "24 hour Order Check"...The verifying nurse's name and professional designation...The date (day, month, year) and time (including AM or PM that the Order was verified..." Medical record review of the 24 Hour Nursing Chart Audit form for resident #11, dated July 13, 2011, through August 9, 2011, revealed no documentation the audit was completed on July 18, 20, 21, 23, 26, 27, 28, 29, 30, 31, and August 1, 4, 2011. Interview with Registered Nurse (RN) #1 in the conference room on August 18, 2011, at 12:20 p.m., confirmed RN #1 transcribed the order incorrectly into the ECS on the MARs. Further interview confirmed RN #1 was the nurse who completed the 24 Hour Nursing Chart Audit on August 5, 6, and 7, 2011. Interview with the resident's attending physician in the conference room on August 17, 2011, at 9:30 a.m., revealed the physician had been notified of a Coumadin medication error on August 9, 2011, the same day the resident was admitted to the hospital for an elevated INR. Continued interview with the physician revealed the resident was to	F 333	orders on a 24 hour basis, seven days a week. For residents who are readmitted, all prior physicians' orders are discontinued by the Corporate RN Admission Coordinator or designee just prior to entering all new orders into the ECS. Therefore, all physicians' orders should reflect the date of the readmission to the facility. The Administrator and/or IDON are notified of any after five pm or weekend admissions by the Corporate RN Admission Nurse, Facility Admission Nurse, Social Worker or RN Team Leader to assure the appropriate follow up is implemented. This notification generally occurs before the resident arrives and is at a minimum within four hours after the resident has been admitted to the facility. If the Corporate RN is unavailable to initiate the usual process, the RN Team Leader enters the physician medication orders. A second RN Team Leader reviews the medication orders and matches it to the MAR. Then, a RN/LPN Medication Nurse conducts a final review matching the physicians medication orders to the MAR prior to the medications being administered. The IDON instructed the RN Team Leaders and LPN involved on this process on August 27, 2011. The Administrator or IDON reviews the process with the team to assure no medication transcription errors occur and the process is followed. This notification process began on January 16, 2011 and was revised on August 27, 2011 to assure that the order double check process could occur timely, within 24 hours from admission and the process is ongoing. On August 16, 2011, all team leader nurses were in-serviced by IDON, an LPN, and Nurse Educator regarding physician order	

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F 333	Continued From page 15 receive alternating doses of 3 mg and 4 mg of Coumadin on alternate days; and stated the resident received 7 mg of Coumadin on August 6, 7, and 8, 2011. Continued interview with the physician confirmed, "If the error occurred as told to me, this is the reason for the elevated INR." Interview with LPN #1 in the conference room on August 18, 2011, at 9:00 a.m., via telephone, confirmed LPN #1 administered the wrong dose of Coumadin on August 6, 2011. Further interview confirmed LPN #1 did not read the order thoroughly, and stated "I saw it said Coumadin orders...saw the spaces that were open (where the nurse initials the Coumadin upon administering) and administered the Coumadin according to the open spaces within the two blocks." Interview with LPN #2 in the conference room on August 18, 2011, at 11:05 a.m., via telephone, confirmed LPN #2 administered the wrong dose of Coumadin on August 7, and 8, 2011. Further interview confirmed LPN #2 did not read the order thoroughly, and stated "The MAR showed both doses of Coumadin (3 mg alternating with 4 mg)...I have a habit of looking at the spaces of days open and did not read the order...I didn't question the amount to be given." Interview with RN #1 in the conference room on August 18, 2011, at 12:20 p.m., confirmed RN #1 found the physician's order on August 5, 2011, for Coumadin Monday, Wednesday, Friday, 3 mg...Sunday, Tuesday, Thursday, Saturday, 4 mg lying on the desk, not processed, picked it up and entered it into the ECS, without validating accuracy. RN #1 confirmed "I entered it according	F 333	entry including alternating doses and one time only doses of medications in the ECS, as well as lab monitoring and medication administration. This began the one hundred percent education to all licensed nursing staff. The education was completed with all licensed staff on August 22, 2011. Additionally, licensed nurses are trained on ECS during orientation by the Nurse Educator or designee. This includes how to enter physician orders. In order to assist licensed nurses, ECS reference cards were initiated on August 28, 2011. These reference cards are located on each nursing wing with instructions on how to use the ECS system. Included in this is a card on how to enter physician medication orders into the ECS system. These reference cards provide step-by-step instructions to the licensed nursing staff regarding ECS. These cards follow the one-on-one return demonstration education, which was provided by the Corporate RN and her designee and reinforces this education (see below) Additionally, medication pass audits are being conducted weekly on licensed nursing staff including licensed nursing agency staff by the IDON, Nurse Educator and RN Team Leaders. This audit tool was revised in April, 2011 and weekly audits began on August 8, 2011. These audits check to assure the licensed nurse identifies the resident prior to administering medication, and that the correct medication is given to the resident in the correct dose, by the correct route and at the right time. The monitor ensures residents who receive	

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F 333	Continued From page 16 to the order but I neglected to confirm it was correct on the MAR as ordered...I neglected to double-check it." Continued interview with RN #1 confirmed all new and re-admission orders are obtained and entered by the Corporate Nurse...changes in other orders are entered by the Team Leaders (Registered Nurses) and double-checked by the Medication Managers (Licensed Practical Nurses). Interview with LPN #5 (a Medication Manager) on Central Hall on August 18, 2011, at 4:05 p.m., confirmed LPN #5 does receive and process orders into the computer (ECS). Continued interview with LPN #5 confirmed "sometimes I have a second nurse to verify the order and sometimes not." Interview with LPN #4 on East Hall on August 18, 2011, at 4:10 p.m., confirmed LPN #4 stated, "I have been working at the facility for two weeks and have not been trained on the process for physician orders." Interview with LPN #3 (a Unit Manager) in the conference room on August 18, 2011, at 4:30 p.m., confirmed LPN #4 had not been trained on the computer (ECS) and the process for physician orders. Interview with RN #2 in the conference room on August 19, 2011, at 9:30 a.m., via telephone, confirmed RN #2 received a faxed order on August 5, 2011, for the Coumadin (3 mg alternating with 4 mg) from the physician's office. RN #2 confirmed "I didn't know how to enter the order into the ECS...I was trained in ECS but, ECS is not user-friendly."	F 333	medications that need monitoring are reviewed or assessed prior to the administration of the medication (i.e. Digoxin, Coumadin, etc.). When applicable, lab values are checked by the RN/LPN prior to medications being given in accordance with physician orders. A one on one in service "return demonstration for accurate order entry" was conducted with the licensed staff on 8-28 through 8-30-2011 by clinical resources outside the facility. This included the entry of a Coumadin order that required a special pattern setup, an antibiotic order, a once monthly order and an every other day order that started on a future date. The licensed nurse was observed as the orders were written, education provided when needed and checked off for competency when completed. Contract labor registered nurses and licensed nurses working in the facility during the time frame of the above listed in services also participated in the educational process. New or returning licensed staff members including licensed agency staff will receive one-on-one education with return demonstration for accurate order entry as stated above and will be checked off for competency before working on the units by the Nurse Educator, IDON, or designee.	

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F 333	Continued From page 17 Interview with LPN #6 on West Hall on August 19, 2011, at 1:25 p.m., revealed "If I had an emergency, I would write the (physician's) order but, I don't know about putting it in the computer or who to fax it to." Interview with the Interim DON with the Administrator present in the conference room on August 19, 2011, at 3:10 p.m., revealed the Interim DON confirmed the facility failed to ensure the Coumadin was given as ordered for three consecutive days on August, 6, 7, and 8, 2011. In summary, when a physician's order for Coumadin was received on August 5, 2011, the facility failed to administer the medication according to the order resulting in over-dosing the medication for three consecutive days: August 6, 7, and 8, 2011. The overdose of the Coumadin caused the resident to have a critically prolonged clotting time which required hospitalization and treatment to reverse the effect of the medication overdose, in order to prevent uncontrolled bleeding and the likelihood of death. C/O #28552	F 333		